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Item 11(a)(b)(c) Physical Therapy, Occupational Therapy, and Services for Individual with Speech, Hearing and Language Disorders

Therapy and related services provided on an outpatient basis require prior approval.

The following services are not a benefit of the New Mexico Medicaid Program:

1. Services classified as educational.

2. Services provided by home health agencies, independent physical therapists, or out-patient rehabilitation centers to patients in a skilled nursing facility or an inpatient hospital.

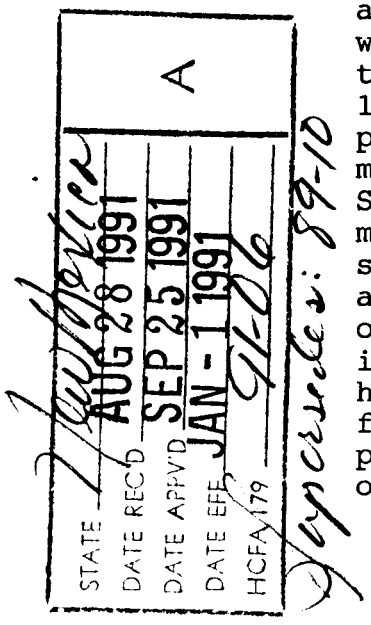
3. Speech therapy provided by speech therapists unless certified as a rehabilitation center.

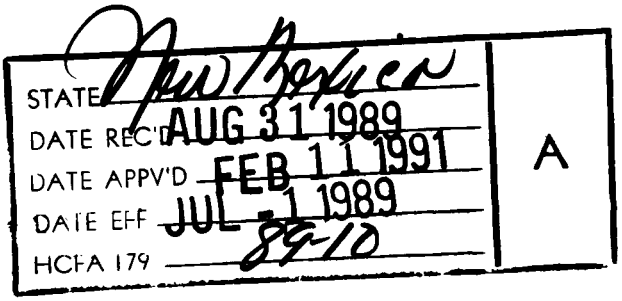
Item 12(a) Prescribed drugs

Limitations are as follows:

a. Drugs rated as ineffective by the FDA are not a benefit of the program.

b. The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3) or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. The State will cover new drugs of participating manufacturers (except excluded/restricted drugs) for six months after Food and Drug Administration approval and upon notification by the manufacturer of a new drug. Any prior authorization program instituted after July 1, 1991 will provide for a 24 hour turnaround from receipt by mail of the request for prior authorization. The prior authorization program also provides for at least a 72 hour supply of drugs in emergency situations.

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c. Coverage of drug items is subject to the following program restrictions. Exceptions to these restrictions can be considered on a prior approval basis as indicated below.

1. Appetite suppressants and other drugs used for obesity control, are not program benefits.

2. Vitamins and multiple vitamins are a benefit of the program for pregnant or lactating women, for infants up to one year of age, and for patients in nursing homes. Coverage of these items for other conditions require prior approval.

3. Barbiturate hypnotic drugs (barbiturate drugs whose primary action is to induce sleep) are covered for patients in nursing homes.

   For patients not in nursing homes, coverage of those items may be authorized on a prior approval basis.

4. Flu and pneumococcal vaccines are covered only when one of the following conditions exits:

   a. Acquired or congenital heart disease such as valve disease, congestive heart failure, or pulmonary overload.

   b. Conditions which compromise pulmonary or renal functions, or the immune mechanisms.

   c. Metabolic disorders.

   d. Severe anemias including sickle cell diseases.

   e. All persons over age 65.

   f. Conditions which are included in the seasonal recommendations of the Public Health Services.

5. The following non prescription drugs items, are covered without prior approval, but only when prescribed by a licensed physician or other licensed practitioner.

   a. Aspirin, acetaminophen, ibuprofen, and single entity antihistamines, antitussives, and expectorants.

   b. Antacids.

   c. Prenatal multiple vitamins for pregnant or lactating women.

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d. Single entity vitamins or multivitamins for patients in nursing homes.

e. Insulin.

f. Ferrous salts (iron supplements) as single entity drugs. Long acting, sustained release, or combination products are not a benefit of the program.

g. Oral electrolyte replacement solutions for treatment of diarrhea.

h. Agents for bowel preparation preceding diagnostic examination.

6. Non-prescription drugs are generally limited to the exceptions described in this section. However, other non-prescription items may be considered on a prior approval basis as follows:

a. Cerbral stimulants

b. Cathartics and laxatives

c. Non-sustained release hemitinics

d. Antihistamine

e. Analgesic and Antipyretic

f. Anxiolytics and Sedatives

g. Dental agents

h. Diagnostic agents

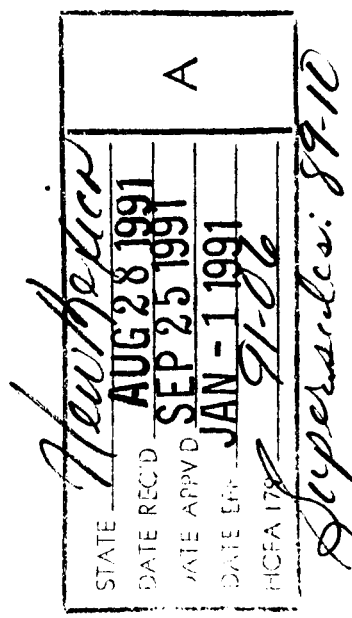
i. Salt & Sugar Substitutes

j. Enzymes

k. Antitussives, Expectorants and Mucolytic agents

l. Eye, Ear, Nose and Throat preparations

m. Gastrointestinal drugs



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n. Skin and mucous membrane agents

o. Vitamins and Minerals

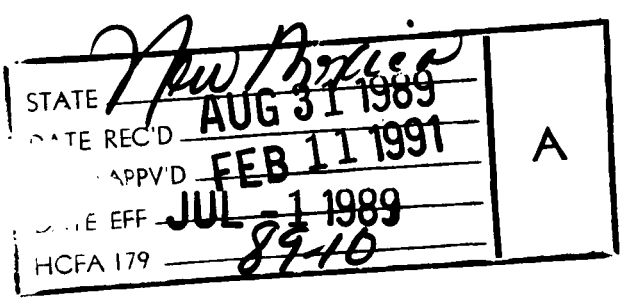
7. Orphan drugs (drugs used in the treatment of rare diseases), drugs used for unlabeled purposes, and very expensive drugs not routinely stocked in pharmacies may also require prior approval, only if in Section 1927 (k)(6).

8. The following drug items are not covered under the program:

   a. Medication supplied by the State Hospital to recipients on convalescent leave from the hospital.

   b. Non-drug personal care items.

   c. Cosmetic items are also not a benefit of the program (e.g.: Retin-A for aging skin, Rogain for hair loss).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d. Medical Supplies and Durable Medical Equipment

D.M.E. is considered for coverage only if it is reasonable and necessary for treatment of an illness or injury, or to improve the functioning of a body part. Many items require prior approval . A list is available from the Medical Assistance Division.

Services and items not a benefit of the Medicaid Program include those which:

1. Do not primarily and customarily serve a therapeutic purpose and/or are generally used for comfort or convenience purposes;

2. Are environment control equipment not primarily medical in nature (e.g., air cleaner);

3. Are items of institutional equipment inappropriate for home use (e.g., air-fluidized bead bed;

4. Are not generally accepted by the medical profession as being therapeutically effective (e.g., auto-tilt chair); or are determined by Medicare regulations not to be effective or necessary.

5. Are hygienic in nature (e.g., home type bed baths);

6. Are covered only as a hospital or physician diagnostic items (i.e., Electrocardiocorder);

7. Are instruments or devices manufactured for use by a physician (i.e., esophageal dilator);

8. Are not essential to administration of moist heat therapy (i.e., hydrocollator heating unit);

9. Are exercise equipment not primarily medical in nature;

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10. Are items which produce no demonstrable therapeutic effect (i.e., Myoflex muscle stimulator);

11. Are items of support exercise equipment primarily for institutional use (i.e., parallel bars) where, in the home setting, other devices satisfy the recipient's need (e.g., a walker);

12. Are not reasonable or necessary for monitoring the pulse of a homebound recipient with or without a cardiac pacemaker (e.g., pulse tachometer);

13. Are used to improve appearance or for comfort purposes (i.e., sauna baths, wigs);

14. Are precautionary in nature (i.e., spare tanks of oxygen in addition to a portable backup system);

15. Are emergency communications systems and do not serve a therapeutic purpose.

Multiple services are not covered. Recipients are limited to one wheelchair, one hospital bed, etc.

Interest and/or carrying charges are not covered.

The delivery of D.M.E. is covered only when the equipment is initially purchased or rented; when the supplier customarily makes a separate charge for delivery; and only for delivery charges of over 75 miles (round trip).

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Item 12(d) Eyeglasses

a. Coverage of eyeglasses (frames and lenses) are subject to the following criteria.

1. Diopter correction must meet or exceed one of the following:

(a) -1.00 Myopia (nearsightedness)
(b) +1.00 Hyperopia (farsightedness)
(c) ± .75 Astigmatism (distorted vision)
(d) ±1.00 Presbyopia (farsightedness of aging)

2. If updating an existing prescription, the visual acuity must be 10/40 far vision, 20/30 near vision, or worse in the poorer eye with the old glasses, and/or at least 3/4 diopter change in prescription. Exceptions will be made for persons with cataracts and children under the age of 18.

3. For bifocal lenses, a correction of .25 or more for distance vision and 1 diopter or more for add.

4. For prism, a total correction of 2.00 diopters or more. Above lens criteria will not apply.

5. For tinted, filtered, or photochromic lenses, the examiner must document the condition which makes the lenses medically necessary.

The dioptric criteria listed above must be met in addition to the condition which requires tinted, filtered, or photochromic lenses.

b. The following services are not covered by the New Mexico Medical Assistance Program:

1. Orthoptic assessment and treatment.

2. Oversize frames and oversize lenses.

3. Low vision aids.

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4. Contact Lenses, except when prior authorized.
5. Glass cases.

Item 13 d Rehabilitative Services

Services are limited to mental health rehabilitation services for eligible recipients for whom the medical necessity of such services has been determined and who are not residents of an institution for mental illness.

The services are limited to goal oriented mental health rehabilitative services individually designed to accommodate the level of the recipient's functioning and which reduce the disability and to restore the recipient to his/her best possible level of functioning.

Services are limited to assessment, treatment planning, and specific services which reduce symptomatology and restore basic skills necessary to function independently in the community including:

1. Therapeutic Interventions: Provides face to face therapeutic services which include assessments, treatment planning, ongoing treatment, and transition planning.

2. Medication Services: Provides for the assessment of the efficacy of medication and evaluation of side effects, and administration of medication by qualified personnel when it cannot be self administered. Also provides educationally structured face to face activities delivered to patients, their families and others who provide care to patients regarding medication management.

3. Community Based Crisis Interventions. Provides coordinated services utilizing a crisis team. The service includes immediate access, evaluation, crisis intervention and respite care to patients.

4. Professional Consultation: Provides consultation services by mental health professionals as part of treatment team, to patients for the purpose of clinical case review, treatment plan development and ongoing treatment.

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